GAMP Renewal Application Form

You may only use this form if you have been on GAMP between 11-1-06 and 4-30-08. If you applied on or after 5-1-08 you do not need to renew your GAMP eligibility you will automatically be enrolled in BadgerCare Plus Core Plan.

Applicant Information

Last Name_____ **First**_____ **MI** _____

Date of Birth (Month/Day/Year)_____ **Social Security Number** _____

Spouses Information (Leave blank if you do not have a spouse or are separated from your spouse)

Last Name_____ **First**_____ **MI** _____

Date of Birth (Month/Day/Year)_____ **Social Security Number** _____

❑ Check here if your spouse does not wish to apply for GAMP.

1. Has any of the following information changed since you last applied for GAMP?

❑ Yes or Unsure, Please update below ❑ No

Name/Marital Status _____

Address _____

_____

Phone Number _____

2. Is your Gross Income (before any taxes or deductions are taken out) still under $902 per month? OR, if you listed a spouse is your household's gross income still under $1166 per month?

❑ Yes ❑ No

3. If you are employed, does your employer offer insurance?

❑ Yes ❑ No

4. Are you legally disabled (If you have applied for Social Security Disability or SSI and have not received a decision yet, check no)?

❑ Yes ❑ No

5. Do you have placement and care of your child at least 40% of the month or do you have care and custody of a relative's child through a court order or Kinship Care?

❑ Yes ❑ No

Over

Clinic Choice (please choose a primary care clinic)

❑ **Angel of Hope Clinic**
209 W Orchard Street
Hospital: Wheaton Franciscan

❑ **ARC of Wisconsin**
820 W Plankinton Av
Hospital: Froedtert

❑ **I. Coggs Heritage Health**
8200 W Silver Spring Dr
Hospitals: Wheaton Franciscan

❑ **Family Medical Clinic**
5436 W Capitol Dr
Hospital: Aurora

❑ **Healthcare for the Homeless**
(St. Ben's)
1027 N 9th Street
Hospital: Columbia/St Mary's

❑ **Hillside Clinic**
1452 N 7th Street
Hospital: Froedtert

❑ **Gerald L. Ignace Indian Health Center**
1711 S 11th Street
Hospital: Froedtert

❑ **Lisbon Avenue Clinic**
3522 W Lisbon Avenue
Hospital: Froedtert

❑ **Lubsey Clinic**
5300 W Villard Avenue
Hospital: Wheaton Franciscan

❑ **Marquette Women and Children's Clinic**
1218 N 13th Street
Hospital: Columbia/St. Mary's

❑ **MLK Heritage Health**
2555 N Martin Luther King Dr
(414) 372-8080
Hospital: Aurora

❑ **Medpoint Family Care**
2501 W Silver Spring
Hospital: Columbia/St. Mary's

❑ **St Michael's Family Care**
2400 W Villard Avenue
Hospital: Wheaton Franciscan

❑ **Sixteenth Street Community Clinic**
1032 S 16th Street and
2906 S 20th Street
Hospital: Columbia/St Mary's

❑ **Clarke Square**
1818 W National Ave
Hospital: Aurora

❑ **Recovery**
210 W Capitol Dr
Hospital: Aurora

Please read this section carefully before signing this application. This section contains information about your rights and responsibilities.

- I certify, under penalty of false swearing, that the information provided is correct and complete to the best of my knowledge.
- I understand and agree to provide documents to prove that what I have said is true.
- I understand that the penalties for giving false information include denial of benefits, sanction, criminal prosecution, and repayment for any medical benefit payments made by Milwaukee County General Assistance Medical Program (GA-MP).
- I also certify that I am not covered by or eligible to be covered by any healthcare program or insurance.
- I authorize the Milwaukee County GA-MP to verify the information I have provided.
- I understand that my Protected Health Information will be used for the administration and verification of GA-MP benefits.
- I authorize Milwaukee County to contact other persons or organizations to obtain the necessary proof of my eligibility and level of benefits.
- I acknowledge and agree that facts as stated in this application may be subject to private investigations for verity.
- I understand that completing this application does not guarantee that medical bills will be covered and that I am responsible for any co-payments or non-covered/unauthorized services.
- I understand that I am required to pay any applicable processing fees to be certified as a GA-MP recipient.
- I also understand that if this application is approved I will be designated as medically indigent according to state statute and county ordinance.
- I authorize the Milwaukee County GA-MP to access, review, and collect information regarding the medical services I have received in order to verify cost or quality of service by a medical provider or to address other management and/or payment issues as may be determined to be in the best interest of the county.
- Furthermore, I understand and consent to the sharing of this information with other County, State or Federal entities or authorized service/medical providers in order to coordinate service delivery.
- I understand that any co-payment or repayment owed will be pursued for full collection.
- I understand that Milwaukee County may attach my property and/or garnish my income or assets that it is legally entitled to attach and garnish.

Date	Applicant Signature (required)	Spouse's Signature (required only if spouse is applying)

I hereby attest by my signature that I have verified the identity of the applicant by a photo ID or because this person is known to me because I am a provider of his/her medical services.

Date	Witness Signature	Witness Name/Facility (please PRINT)